EVALUATION OF POLICIES AND PROCEDURES FOR JUVENILE OFFENDERS

AND

BEST PRACTICES FOR THE TREATMENT AND MANAGEMENT OF ADULT SEX OFFENDERS AND JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES

A Report of Findings per
16-11.7-103(4)(k) and 16-11.7-109(2) C.R.S.

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Purpose

This legislative report fulfills two statutory requirements:

1. *Evaluation of Policies and Procedures for Juvenile Offenders*[1]. In compliance with C.R.S. 16-11.7-103(4)(k), this legislative brief provides the findings from an evaluation that examines the effectiveness of the *Standards and Guidelines for the Evaluation, Assessment, Treatment and Supervision of Juveniles who have Committed Sexual Offenses* (*Juvenile Standards and Guidelines*). This evaluation of the *Juvenile Standards and Guidelines* focuses strictly on juveniles because an outcome evaluation on the *Adult Standards and Guidelines* was conducted and published in 2011. For information regarding best practices and outcomes related to the *Adult Standards and Guidelines*, please see Attachment A. This study estimates the impact of the implementation of the *Juvenile Standards and Guidelines* on recidivism (measured by new court filing[2] for a misdemeanor or felony) by comparing two groups of youth. One group was sentenced to probation on a sexual offense BEFORE the *Juvenile Standards and Guidelines* were implemented during FY1999 and the other group of was sentenced to probation for a sexual offense AFTER the *Juvenile Standards and Guidelines* were implemented during FY2007. Eighty case files were also reviewed, and four focus groups were held, and findings are presented below. A full technical report on the evaluation will be made available upon request.

2. *Best Practices for the Treatment and Management of Adult Sex Offenders and Juveniles who have Committed Sexual Offenses*[3]. Additionally, this legislative brief also offers three legislative recommendations pursuant to C.R.S. 16-11.7-109(2).

Key Findings

Research Objective 1: Recidivism Outcomes

This analysis compared five year recidivism rates of 205 juveniles adjudicated for a sexual offense and sentenced to probation BEFORE the *Juvenile Standards and Guidelines* were implemented with 289 juveniles adjudicated for a sexual offense and sentenced to probation AFTER the *Juvenile Standards and Guidelines* were implemented.[4]

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[1] C.R.S. 16-11.7-103(4)(k): Evaluation of policies and procedures for juvenile offenders. The board shall research and analyze the effectiveness of the evaluation, identification, and treatment procedures developed pursuant to this article for juveniles who have committed sexual offenses. The board shall revise the guidelines and standards for evaluation, identification, and treatment, as appropriate, based upon the results of the board's research and analysis. The board shall also develop and prescribe a system to implement the guidelines and standards developed pursuant to paragraph (j) of this subsection (4).

[2] It is important to note, however, that recidivism rates are not indicative of true reoffense rates because not all offenses are detected and reported to authorities. Thus, recidivism rates are often underestimates of actual reoffense rates.

[3] C.R.S. 16-11.7-109(2): On or before January 31, 2012, and on or before January 31 each year thereafter, the board shall prepare and present to the judiciary committees of the senate and the house of representatives, or any successor committees, a written report concerning best practices for the treatment and management of adult sex offenders and juveniles who have committed sexual offenses, including any evidence based analysis of treatment standards and programs as well as information concerning any new federal legislation relating to the treatment and management of adult sex offenders and juveniles who have committed sexual offenses. The report may include the board's recommendations for legislation to carry out the purpose and duties of the board to protect the community.

[4] These youth represent all those sentenced to probation during FY 1999 and FY 2007.

1. **Sexual Recidivism**[5]
    - 10.7% (n=22) of the pre-implementation group (FY1999) received a filing for a new sex offense.
    - 3.1% (n=9) of the post-implementation group (FY2007) received a filing for a new sex offense.
        - This decline in sexual recidivism from FY1999 to FY2007 is statistically significant, meaning that the difference is unlikely to be due to chance.
    - Juveniles who successfully completed probation from the pre-implementation group (FY1999) had a sex offense recidivism rate of 8.0% (n=11) compared to a rate of 2.3% (n=4) for those who successfully completed probation from the post-implementation group (FY2007).
    - Juveniles from the pre-implementation group appeared to recidivate sexually faster than the post-implementation group.
        - This finding was not statistically significant, meaning the difference may be due to chance alone.

2. **Violent Non-Sexual Recidivism**[6]
    - 16.6% (n=34) of the pre-implementation group (FY1999) received a new filing for a violent, non-sexual offense after five years.
    - 7.6% (n=22) of the post-implementation group (FY2007) received a new filing for a violent, non-sexual offense after five years.
        - This decline in violent, non-sexual recidivism from FY1999 to FY2007 is statistically significant.
    - Juveniles from the pre-implementation group appeared to recidivate in a violent, non-sexual manner faster than the post-implementation group.
        - This finding is not statistically significant.

3. **Non-Violent, Non-Sexual Recidivism**[7]
    - 30.2% (n=62) of the pre-implementation group (FY1999) received a new filing for a nonviolent, non-sexual offense after five years.
    - 34.6% (n=100) of the post-implementation group (FY2007) received a new filing for a nonviolent, non-sexual offense after five years.
        - This increase in non-violent, non-sexual recidivism from FY1999 to FY2007 is not statistically significant.

4. **Successful Discharges from Probation**
    - 68.8% of the pre-implementation group (FY1999) successfully discharged from probation.
    - 59.9% of the post-implementation group (FY2007) successfully discharged from probation.
        - This decrease in successfully discharges from FY1999 to FY2007 is not statistically significant. However, it is important to note that 79% of juveniles adjudicated for a sex offense successfully discharged during FY2012 and success rates are continuing to improve.

[5] Sexual crimes include sexual assault, incest, public indecency, and sexual exploitation. Failure to register as a sex offender is excluded.
[6] Violent, non-sexual crimes include homicide, robbery, kidnapping, and assault.
[7] Crimes such as drugs, burglary, theft, forgery, fraud, and other property crimes are defined as non-sexual, non-violent.

Research Objective 2: Therapeutic Programming and Supervision Strategies

A case file review of 80 juveniles[8] adjudicated and sentenced to probation in the 1st, 13th, and 21st Judicial Districts during FY 1999 and FY 2007 found the following:

1. **School Personnel Involvement on the Multi-Disciplinary Team (MDT)**[9]
    - Comparing cases adjudicated in FY1999 with cases adjudicated in FY 2007, this analysis found that school personnel were more involved with the MDT after the implementation of the *Juvenile Standards and Guidelines*.
    - Comparing case outcomes, juveniles were more likely to succeed in treatment and supervision when a school representative was a part of the MDT.
        - These findings were statistically significant, but should be viewed with caution given the small sample size.

2. **Polygraph Exam**[10]
    - After the implementation of the *Juvenile Standards and Guidelines* (FY2007), the polygraph exam was used more often than during the pre-implementation period (FY1999). The average number of polygraph exams administered increased from 2 to 5 between pre- and post-implementation of the *Juvenile Standards and Guidelines*.
    - Juveniles were more likely to successfully complete probation supervision if they received a polygraph examination compared to those that did not receive a polygraph examination.
    - A higher number of polygraphs administered to a juvenile was correlated with treatment failure.
        - This finding is confounded by the fact that higher-risk juveniles may be subject to more polygraph assessments.[11] Specifically, polygraph exams are more likely to be administered when the juvenile is exhibiting risk behaviors. Behaviors that may often lead to additional polygraph exams can include non-compliance, persistent denial, and criminal violations.
        - These findings were statistically significant, but should be viewed with caution given the small sample size.

3. **Family Involvement in Treatment**
    - When a juvenile's family was involved in any part of the treatment process, the likelihood that a juvenile would successfully complete supervision increased four-fold.

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[8] This sample was a sub-set of the overall sample of those juveniles adjudicated and sentenced to probation during FY1999 and FY2007.

[9] The *Juvenile Standards and Guidelines* support a coordinated system in which a Multi-Disciplinary Team (MDT) provides each juvenile with an individualized plan that targets both psycho-social deficits and potential risks factors, while concurrently building upon the juvenile's resiliency and other positive traits. The MDT commonly consists of a supervising officer, treatment provider, polygraph examiner, and may include a victim representative, school representative, and parent/guardian, as well as the caseworker, and placement staff where applicable. These members share information and decision making while prioritizing public safety.

[10] For more information on the polygraph, please see the literature review in Appendix A.

[11] Risk assessment data was unavailable for this analysis.

        - This finding was statistically significant, but should be viewed with caution given the small sample size.
    - Between the pre- and post-implementation of the *Juvenile Standards and Guidelines,* the participation of family members on the Multi-Disciplinary Team did not significantly change.

Research Objective 3: Perceived Effects and Usefulness by Field Practitioners

Four focus groups were conducted in the 1st, 13th and 21st Judicial Districts, with a total of 12 participants (e.g., therapists, probation officers, and polygraph examiners) who have supervised and managed sexually abusive youth during pre- and post-implementation periods of the *Juvenile Standards and Guidelines*. Service providers and probation officers who participated in focus groups consistently noted the following:

1. **Utility to Professionals**
    - Overall, participants felt that the *Juvenile Standards and Guidelines* are an effective, research-based tool that help with their jobs. Some participants were especially pleased with some of the more recent revisions to the *Juvenile Standards and Guidelines* including those that address the developmentally disabled population.
    - Collaboration has increased between MDT members, and focus group participants believed this collaboration led to better outcomes for youth.
    - The presence of the MDT has promoted consistency and has provided the following benefits:
        - Families have a standardized support network that can deliver individualized programming to the youth;
        - Behavioral expectations are established early in the treatment/supervision process, so that parents, care-givers and the juveniles themselves are not surprised.

2. **Victim Services**
    - A variety of barriers to victim representation on the MDT were identified by focus group participants, and these have limited the degree to which victim needs can be fully addressed.

3. **Other Challenges and Barriers**
    - Some jurisdictions, especially rural areas, lack treatment providers.
        - In these areas, probation officers work with out-of-town providers to ensure juveniles receive services.

Conclusion

Recidivism. The findings outlined in this report denote recidivism rates consistent with national trends (Reitzel & Carbonell, 2006; Worling & Langstrom, 2006; McCann & Lussier, 2008; Caldwell, 2010). In this study, the sexual recidivism rate decreased by 7.6 percentage points (10.7% to 3.1%) and the violent, non-sexual recidivism rate decreased by 9 percentage points (16.6% to 7.6%) after the *Juvenile Standards and Guidelines* were implemented. Juveniles who committed sexual offenses were significantly more likely to recidivate with non-sexual crimes than sexual ones.

Based on the literature reviewed and the data collected and analyzed for the present study, there is some evidence to suggest that the *Juvenile Standards and Guidelines* may have contributed to the reduction in sexual recidivism. Non-violent, non-sexual recidivism rates were unchanged before and after the *Juvenile Standards and Guidelines* were implemented. It is important to note, however, that recidivism rates are not indicative of true reoffense rates since most sexual assaults are not reported to authorities.

Other findings. Positive findings were associated with the presence of the MDT. A school representative on the MDT was linked to better treatment/supervision outcomes for juveniles. The use of the post-adjudication polygraph examination increased after implementation of the *Juvenile Standards and Guidelines*, and juveniles taking polygraph examinations were more likely to successfully complete probation. However, higher numbers of polygraph examinations were associated with treatment failure but this finding is confounded by the fact that higher risk youth generally receive more polygraph exams.

When a youth's family was involved in the treatment process, the likelihood of treatment success increased four-fold. Unfortunately, comparing cases from FY 1999 and FY 2007, there was no greater involvement of family members in the juvenile's case management after the *Juvenile Standards and Guidelines* were implemented.

Data collected from focus groups found that professionals believe the *Juvenile Standards and Guidelines* are helpful to them, and they especially noted the value of the MDT in promoting consistency, adding a school representative to the decision making process, and providing clarity and support to the family and the youth. Barriers to full implementation of the *Juvenile Standards and Guidelines* included the difficulties associated with ensuring victim representation on the MDT and the lack of local services in rural areas of the state.

Questions persist regarding identifying and implementing evidence-based practices that address the complex issues related to juveniles who commit sexual offenses. In Colorado, the SOMB has integrated numerous perspectives into the *Juvenile Standards and Guidelines.* Yet, more research is required to study the variety of practices, policies and procedures related to the effective evaluation, assessment, treatment, and supervision of juveniles who have committed sexual offenses. The core components that first defined the containment model remain unchanged, but have evolved to incorporate new and innovative practices—many of which are either research-based or evidence-based—enabling the containment model to still be an effective management strategy.

Recommendations

SOMB:

1. ***Juvenile Standards and Guidelines*** – Continue to utilize the *Juvenile Standards and Guidelines* by building upon its current research-based practices to integrate new research and emerging trends from the literature. This should follow the currently adopted process of periodically conducting revisions based on new research and best practice, and updating the literature references.

2. **Holistic Treatment Model** – Enhance and expand upon sex offense-specific treatment for juveniles who have committed sexual offenses to include health promotion and strength- based approaches, and expand treatment interventions to address non-sexual, criminogenic factors that may result in non-sexual criminal recidivism.

3. **Recidivism Research** – Continue to utilize the data from this study, and periodically research the recidivism of juveniles who have committed sexual offenses.

4. **School Reference Guide and School Representatives** – Prioritize and update the School Reference Guide in order to emphasize the importance of incorporating school representatives into the MDT and further develop research-based school strategies.

5. **Diversion Education Initiative** – Continue to educate legal and clinical stakeholders by expanding the continuum of sentencing and treatment options available to by implementing diversion and boundary training. Supervision and treatment interventions that are commensurate with a juvenile's criminogenic needs and level of risk present the best opportunity for successful rehabilitation of the juvenile, ensuring community safety. Concerns related to the criminogenic impact of placing low-risk juveniles with high risk juveniles and unnecessary labeling of juveniles need to be incorporated into the juvenile justice response to this population. The SOMB is specifically concerned about the current trend of some juveniles engaging in sexting behavior, and in properly responding to this behavior rather than unnecessarily charging, supervising, and treating this behavior as sexually abusive. The SOMB is in the process of providing education to community groups, professionals, and others about how to prevent the occurrence of this behavior as well as how to intervene appropriately when it occurs.

6. **Rural Initiative** – To expand the availability of treatment in underserved areas, continue to advance the Rural Initiative via the ongoing development of a treatment provider approval process that is a competency-based assessment rather than the current quantitative method of counting clinical and training hours.

7. **Competency-Based Initiative** – The SOMB has recognized that treatment provider expertise should be based on training and reinforcement of learned skills. The SOMB should continue its effort to develop a new treatment provider approval process based on the development of competency skills for providers rather than the current quantitative model of accumulating the requisite number of clinical and supervision hours.

8. **Young Adult Population** – Continue to study the young adult population by developing an Appendix that gives guidance to providers for service delivery and considers the unique dynamics of this population. The SOMB recognizes the research that suggests that developmental factors may play a role in rehabilitation of young adult sexual offenders and is working to incorporate this knowledge into the *Juvenile Standards and Guidelines*.

9. **Polygraph Services** – The polygraph assessment can serve as a valuable adjunct instrument under certain circumstances for juveniles. However, it is not intended, nor should it be used as a stand-alone treatment and supervision tool.

10. **Family Integration** – The SOMB recognizes the important role the family plays in the treatment and supervision of juveniles who commit a sexual offense. The SOMB will continue to study further ways to incorporate families into the MDT, treatment, and supervision process.

Legislative:

NOTE: AS THIS REPORT IS ALSO CONSIDERED TO FULFILL THE REQUIREMENTS OF C.R.S. 16-11.7-109(2), THE FOLLOWING SOMB LEGISLATIVE RECOMMENDATIONS PERTAIN TO BOTH JUVENILES WHO HAVE COMMITTED SEXUAL OFFENSES AND ADULT SEXUAL OFFENDERS FOR BEST PRACTICES.

1. **Residence and Zoning Restrictions** – The SOMB has been actively working on this issue since 2004, when the Colorado General Assembly requested the SOMB to conduct a research study and publish recommendations. It was the position of the SOMB then, as it continues to be now, that it is counter-productive to community safety for residence and zoning restrictions to limit where a sexual offender can live and the ability to place multiple sexual offenders together in a residence for the purposes of enhanced monitoring (Shared Living Arrangement – SLA). The state of Colorado has not passed any such legislation. However, local municipalities and counties have passed ordinances prohibiting certain sexual offender living arrangements. The Colorado Commission on Criminal and Juvenile Justice (CCJJ) requested that the SOMB continue to monitor this issue and provide continued guidance. The SOMB approved the *White Paper on Adult Sex Offender Housing* on November 18, 2011. This *White Paper* includes specific recommendations related to addressing the issue of residence and zoning restrictions (see Attachment B).

2. **The Need for Affordable, Appropriate, and Stable Housing** – As noted above, the SOMB has ongoing concerns about sexual offenders being able to find affordable, appropriate, and stable housing, and published the *White Paper on Adult Sex Offender Housing* in an attempt to address these concerns. Such housing is viewed as an important component of a comprehensive management plan for sexual offenders in the community, and the availability of affordable, appropriate, and stable housing for adult sex offenders is seen as benefitting overall community safety. Offenders who are transient and destabilized present a greater risk for supervision non-compliance (e.g. failure to register) and for sexual recidivism. For more information related to the SOMB's recommendations related to adult sex offender housing, please see Attachment B.

3. **Use of Community Corrections for Sexual Offenders as an Alternative to Incarceration** – Community corrections is an alternative to incarceration for many offenders in the criminal justice system. It can serve as an alternative to the Department of Corrections for offenders who are struggling on probation supervision or as a step-down level of care for offenders leaving a correctional facility (i.e., transition). Until recently, many community corrections programs were not providing services to the sexual offender population. Management of sexual offenders within community corrections requires enhanced training for staff and programming for the offenders. Many community corrections programs are reluctant to invest in these enhancements given the lack of funding available to pay for such training. The SOMB encourages the use of community corrections for sexual offenders in the *White Paper on Adult Sex Offender Housing* (Attachment B). The SOMB recommends an enhanced per diem for sexual offenders in community corrections. The enhanced per diem will encourage the development of needed training and programming.

APPENDICIES

APPENDIX A – LITERATURE REVIEW

Overview

Sex crimes committed by youth. According to The Office of Juvenile Justice and Delinquency Prevention (2009), juveniles commit an estimated 35.6% of the sex offenses that occur in the United States each year. In 2008, the National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children (NISMART) of the Office of Justice Programs reported similar findings: "twenty-nine percent of the sexual assault victims were assaulted by youth age 17 or younger." This translates into an estimated 83,700[12] known victimizations perpetrated by juveniles in the U.S in 1999 alone (Finkelhor, Hammer, & Sedlak, 2008:2, 7). In addition, the actual number of victimizations is likely to be much larger as police were contacted only 30% of the time according to one study (Finkelhor, Hammer, & Sedlak, 2008).

Generally low recidivism rates. While sexual recidivism rates based on official record data are low, ranging from 7.1 to 15% over approximately 5 years,[13] research has consistently shown that official record data underestimates real offense rates. According to Heil et al. (2010), "Reconviction rates represent a diluted measure of the true reoffense rates; hence reconviction rates from professional research should be viewed as representing significant underestimations of sex offender recidivism for contact offenses."

Approach to literature review. To review the most current and relevant studies, the SOMB Research Committee established a working group of 11 volunteers representing different stakeholder groups. This group reviewed over 250 research articles. Any published study that lacked definitions and/or robust methodological designs was excluded from review. The results of this literature review offer an overview of information in three distinct areas: (1) Recidivism Rates for Sexually Abusive Youth; (2) Characteristics of Juveniles who Commit Sexual Offenses; (3) Research-Based Practices.

Recidivism Rates for Sexually Abusive Youth

Recidivism rates vary based on the definition of recidivism, the source of information, and the time period studied. According to studies that use official records of recidivism, juveniles who commit sexual offenses generally have low sexual recidivism rates, ranging from 7.1% to 15% over approximately 5 years (Worling & Langstrom, 2006; Caldwell, 2007). In fact, juveniles who have been adjudicated for sexual offenses are more likely to recidivate with a nonsexual offense than with a sexual offense

[12] This estimate is based on the National Household Survey of Adult Caretakers and the National Household Survey of Youth conducted during 1999. These surveys cover victimizations that occur over a 12-month period. These figures exclude adult victimizations.

(Carpentier and Proulx, 2011). Please see Table 1 for a review of recent meta-analytic studies of recidivism.

Table 1. Meta-Analytic Recidivism Studies of Sexually Abusive Youth

Study (Year)	Age (Range)	Sample Size	Average Follow-up Period (months)	Recidivism Measure	Recidivism	
					Any	Sexual
Reitzel & Carbonell (2006)	14.6 (7 to 20)	K = 9 (N = 2,986)	58.6 (8 to 96)	A = 6, Con = 2, M = 1	N/A	12.5% (7.4% / 18.9%)[a]
Worling & Langstrom, (2006)	15.5 (8 to 20)	K = 22 (N = 2,788)	54.6 (6 to 115)	A = 1, C = 7, SR = 2, Con = 7, M = 4, O = 1	42%	15%
McCann and Lussier (2008)	N/A	K = 18 (N = 3,189)	60		53%	12% (2 to 30)
Caldwell (2010)	14.7 (N/A)	K = 63 (N = 11,219)	59.4 (N/A)	A or C	43.4%	7.1%

Notes: The recidivism measures are defined as follows: A – Any Recidivism; C – Charges; Con – Conviction; SR – Sexual Recidivism; M – Multiple; O – Other.
[a] The percentages in parentheses indicate the treatment versus non-treatment groups.

Risk factors related to recidivism. A meta-analysis of 22 studies conducted by Worling and Langstrom (2006) investigated risk factors linked to sexual recidivism. They identified 23 risk factors and placed them in four different categories based on the level of available evidence: (1) empirically supported, (2) promising, (3) possible, and (4) unlikely. Table 2 summarizes their findings. The empirically supported category is defined by the presence of at least two independent studies that found a statistically significant relationship between the risk factor and the commission of a sexual reoffense. As shown in Table 2, these risk factors include: deviant sexual interests, prior criminal sanctions for sex offending, more than one victim, stranger victim, social isolation, and uncompleted offense-specific treatment. The three other categories highlight risk factors for which there is not yet strong empirical support.

Table 2. Risk Factors Linked to Sexual Recidivism

Empirically Supported High Correlation: At least 2 studies with statistically significant link	**Promising** Moderate Correlation: 1 published study and published in risk-factor checklist	**Possible** No Correlation: Theoretical research support the idea, but empirical evidence is lacking	**Unlikely** Contrary Correlation: No supporting empirical link to sexual recidivism at publication date
• Deviant Sexual Interests	• Problematic Parent-Adolescent Relationship	• High-Stress Family Environment	• Adolescent's Own History of Sexual Victimization
• Prior Criminal Sanctions for Sex Offending	• Attitudes Supportive of Sexual Offending	• Impulsivity	• History of Nonsexual Offending
• More than One Victim		• Antisocial Interpersonal Orientation	• Sexual Offending Involving Penetration
• Stranger Victim		• Interpersonal Aggression	• Denial of Sexual Offending
• Social Isolation		• Negative Peer Associations	• Low Victim Empathy
• Uncompleted Offense-Specific Treatment		• Sexual Preoccupation	
		• Male Victim	
		• Sexual Offending against a Child	
		• Threats, Violence, or Weapons in Sexual Offense	
		• Environment Supporting Reoffending	

Source: Worling and Langstrom (2006).

Additionally, Caldwell (2010) analyzed 63 studies of the outcomes of 11,219 juveniles who committed sexual offenses. This investigation corroborated the notion that juveniles who commit sexual offenses are less likely to persist in sexual offending patterns and more likely continue to engage in non-sexual than sexual criminal activity beyond adolescence and into adulthood. Other research has documented this progression from sexual to nonsexual offenses as youth age into adulthood (Nisbet, Wilson, & Smallbone, 2004) showing adolescents to be more versatile in terms of general delinquency (Vandiver & Teske, 2006; Carpentier & Proulx, 2011). In fact, Caldwell (2007) found that sexually abusive youth were ten times more likely to engage in nonsexual than sexual recidivism.

Characteristics of Juveniles who Commit Sexual Offenses[14]

Comparing youth with sexual behavior problems with delinquent youth. According to Worling & Langstrom (2006:219), "[T]he onset and persistance of severe or violent antisocial behavior in adolescents is the result of complex interactions between a multitude of risk and protective factors." Wijk, Loeber, Hart-Kerkhoffs, Doreleijers, & Bullens (2006:Abstract) reviewed the literature and compared the characteristics of juvenile delinquents with juveniles who commit sexual offenses by way of "personality characteristics, family functioning and background, anti-social attitudes, and intellectual and neurological functioning." These differences were less empirically-based, however, and more qualitative because results across studies were often contradictory or inconclusive.[15] Nevertheless, Wijk et al. concluded that differences could not be drawn. However, youth with sexual behavioral problems were more likely to internalize problems; they tended to have a history of delinquent offending behavior; had more difficulty establishing and maintaining peer relationships; and were more likely to have been sexually abused during their childhood.

The multitude of potential static and dynamic risk factors related to recidivism make grouping this diverse population into homogeneous sub-groups a difficult and complex endeavor (Mulder, Brand, Bullens, & Marle, 2010). Seto & Lalumiere (2010) conducted the most recent and comprehensive meta-analysis of characteristics of juveniles with sexual behavior problems. They examined male adolescents in 59 independent studies by comparing juveniles who have committed sexual offenses (n = 3,855) with juveniles who have not committed sexual offenses (n = 13,393). These two groups were studied on theoretically derived variables reflecting general delinquency risk factors (antisocial tendencies), childhood abuse, exposure to violence, family problems, interpersonal problems, sexuality, psychopathology, and cognitive abilities From this analysis, Seto and Lalumiere (2010) tested seven different etiological theories described in Table 3.

[14] According to Finkelhor, Ormrod, and Chaffin (2009), nearly seven percent of sexual offenses (excluding prostitution) are commited by females.

[15] This review highlighted the methodological limitations associated with systematically reviewing studies that lacked comparable research designs.

Table 3. Etiological Theories for Adolescent Sexual Behaviors

	Theory	Description	References
1	*The Sexually Abused Sexual Abuser**	Male children who are sexually abused are more likely to engage in sexual offending later in life.	Johnson & Knight, 2000; Knight & Sims-Knight, 2003; Kobayashi, Sales, Becker, Figueredo, & Kaplan, 1995; Marshall & Barbaree, 1990
2	*Poor Childhood Attachment*	Poorly attached individuals are more likely to try to fulfill their intimacy needs in inappropriate relationships.	Marshall & Barbaree, 1990; Marshall, Hudson, & Hodkinson, 1993; Righthand & Welch, 2001; Ryan, 1999; Smallbone, 2006
3	*Social Incompetence*	Adolescents who commit sexual offenses have difficulty initiating or maintaining age appropriate and consensual relationships because they have deficits in such skills as approaching someone, engaging them in conversations, and accurately decoding affective cues during interactions with similar-aged peers.	Becker & Kaplan, 1988; Knight & Prentky, 1993; Marshall et al., 1993; Marshall, Serran, & Cortoni, 2000; Worling, 2001
4	*Sexual Development*	Sexually abused individuals are different from non-abused individuals in having an earlier onset of masturbation and greater use of sex as a means of coping with stress and other problems.	Knight & Sims-Knight, 2003; Malamuth et al., 1991; Marshall & Barbaree, 1990
5	*Atypical Sexual Interests**	Some adolescents who commit sexual offenses differ from other adolescents in their sexual interests in children, or in coercive sex with peers or adults motivated by their sexual offenses.	Becker & Kaplan, 1988; Finkelhor, 1984; Hall & Hirschman, 1991, Hall & Hirschman, 1992; Marshall & Barbaree, 1990; Seto, Murphy, Page, & Ennis, 2003; Ward & Siegert, 2002
6	*Psychopathology*	The association of psychopathology and sexual offending reflects an underlying disturbance in serotonergic brain systems, because serotonin levels are associated with mood, sexual behavior, and aggression.	Hall & Hirschman, 1991, 1992; Ward & Siegert, 2002
7	*Cognitive Abilities*	Juveniles with lower cognitive abilities may have poorer judgment or impulse control, and thus, may be more likely to commit sexual offenses opportunistically. Alternatively, persons with lower cognitive abilities may be more likely to be sexually rejected by peers, and thus, may be more likely to turn to children or to engage in sexual coercion against peers or adults.	Cantor, Blanchard, Robichaud, and Christensen, 2005

Source: Adapted from Seto & Lalumiere (2010).
Notes: * indicates significant differences were found between juvenile who commit sexual offenses and juveniles who do not commit sexual offenses.

In sum, Seto and Lalumiere (2010) found previous sexual abuse along with other forms of childhood neglect or abuse to be linked with problematic sexual behavior, wheres non-sexual offenders were more likely to be influenced by antisocial peers and substance abuse (Way & Urbaniak, 2008; see also Hunter and Figueredo, 2000; Grabell & Knight, 2009[16]). Other factors distinguishing sexually abusive youth from non-sexually abusive youth included atypical sexual interests, early exposure to sex or pornography, anxiety, and low self-esteem (Seto & Lalumiere, 2010).

What remains unclear is how these developmental factors interact across multiple psycho-social dimensions to lead some juveniles to specialize in sexual offending and others to reoffend criminally (Caldwell, 2010). Thus, how specific psychosocial developmental properties differentiate among sexually abusive youth is still subject to debate. Heterogeneity within this population has been empirically supported, and warrant the use of individualized treatment plans as required in the *Juvenile Standards and Guidelines*.

[16] Grabell & Knight (2009), while expressing extreme caution about the results,-found that the age group of three to seven was the only age range where sexual victimization demonstrated statistically significant correlations with later abusive behavior. Hunter & Figueredo (2000:Abstract) also found that "a younger age at time of victimization, a greater number of incidents, a longer period of waiting to report the abuse, and a lower level of perceived family support postrevelation of the abuse were found to be predictive of subsequent sexual perpetration."

Sexting and pornography. The communication or transmission of youth-produced sexual images, commonly referred to as sexting, has garnered considerable attention. However, in a study of a nationally representative sample, approximately 7.1% of juveniles reported receiving nude or nearly nude images while 5.9% of youth received sexually explicit images (Mitchell, Finkelhor, Jones, & Wolak, 2011). Wolak & Finkelhor (2011) identified two categories of minors who engage in sexting: (1) aggravated and (2) experimental cases. By definition, aggravated cases are seen to have criminal or abusive elements beyond the production and distribution of sexual images depicting children. Conversely, the experimental cases do not involve any form of malice. Rather, minors who fall into the experimental category are usually attention-seeking or attempting to create or advance imitimate interests (Wolak & Finkelhor, 2011). Juveniles who intentionally view pornography, on the other hand, have been shown to be significantly more likely to engage in delinquent behaviors and substance use (Ybarra & Mitchell, 2005). Yet, the association linking access and consumption of online pornography to sexual abuse is not established in the literature.

Research-Based Practices

Recidivism and treatment effectiveness. In 2004, Walker, McGovern, Poey, and Otis conducted a meta-analysis of ten studies that examined treatment effectiveness based on sexual recidivism. They found that treatment appeared to be generally effective in reducing recidivism (r = .37) with greater effect sizes observed in programs employing cognitive-behavioral or Multi-Systemic Therapy (r = .50). Furthermore, higher effect sizes were also associated with the professional qualifications of the therapist (i.e. licensed psychologists and doctoral students had an r value ranging from .39 to .77, while therapists with a bachelors degree had an average r value of .14). Reitzel & Carbonell (2006) found similar results in their meta-analysis comparing juvenile treatment and non-treatment outcomes in nine studies, five of which included a control group. The recidivisim rate for juveniles who received treatment (7.4%) was significantly lower than the rate for juveniles receiving no treatment (18.9%). Overall, the researchers concluded "that for every 43 sexual offenders receiving the primary treatment who recidivated, 100 of the sexual offenders in the comparison group (i.e., those receiving comparison treatment or no treatment) recidivated" (Reitzel & Carbonell, 2006:409). Despite these promising results, they warn that the higher the quality of the research design, the less likely that differences between the treatment and no-treatment groups were found to be statistically significant. Overall, the treatment efficacy research to date is mixed, but generally low recidivism rates may mean that "many juveniles who commit sexual offenses [can] to move to a non-abusive, healthy and normative path of development" (Leversee & Powell, 2012:19-2 to 19-3).

Therapeutic models. Sex-offense specific treatment encompasses a range of therapeutic models. There is a range of therapeutic models that are encompassed by the broad framework of sex-offense specific treatment. The Relapse Prevention (RP) model remains the primary treatment mode in the field of sex offender management due to its emphasis on risk reduction by treating specific offender behaviors (Leversee & Powell, 2012). Alternatively, research on both adult and juvenile populations has shown

the Risk, Need, Responsivity[17] principles to be an effective strategy, specifically in correctional settings (Andrews & Bonta, 2003; Bumby & Talbot, 2007). Cognitive-Behavioral Therapy (CBT) is considered an evidence-based treatment and is, in fact, the standard sex offense therapeutic intervention (Walker, McGovern, Poey, & Otis, 2004). As previously mentioned, the Reitzel & Carbonell (2006) study showed a moderate effect on treatment effectiveness in their meta-analysis. Multi-systemic Therapy (MST) has been shown to be both cost and clinically effective with the juvenile population (Borduin, Henggeler, Blaske, & Stein, 1990; Letourneau, et al., 2009[18]). While these treatment models appear to be distinct from one another, in clinical practice these are often used together and in combination with individual, group and family modalities.

In response to some of the criticisms of risk management, other models have been developed to incorporate strength-based treatment components that encourage treatment providers to build on each youth's personal strengths ("protective factors"). The Good Lives Model[19] (GLM) (Ward and Brown, 2004; Ward and Gannon, 2006) proposes a positive approach to treatment, and theorizes that there are multiple pathways to repeated sexual abuse (Ward, Mann, & Gannon, 2007). The cornerstone of this model is the notion of self-regulation and the idea that rehabilitation is most effective when adolescents develop and build upon "primary goods." These include personal characteristics such as health, educational or vocational fulfillment, pro-social attitudes, a sense of community, and spirituality, among others. Thus, according to Thakker, Ward, and Tidmarsh (2006), using these "primary goods" to treat potential pathways to sexual reoffense ultimately shifts from a risk management approach to one that is goal-oriented.

Social support and family participation. Juveniles with positive social support networks have been found to be more amenable to treatment (Kimonis et al., 2011). When parents are provided the necessary skill sets to manage dynamic risk factors, particularly after the youth has completed treatment, the youth can experience ongoing support to remain offense free. Multi-Family Group Therapy (MFGT) is another model originally used as an adjunct approach to traditional formats. From a theraputic perspective, the benefits of MFGT are conceived in aiding families with overcoming emotions of shame and isolation in a non-judgmental environment (Nahum & Brewer, 2004).

The Holistic Model. The summation of these models, whether risk or resilient centric, can arguably fit within the Holistic Model (Leversee & Powell, 2012) whereby traditional risk management philosophies are integrated with the concept of health promotion. Within this model, Leversee and Powell (2012) acknowledge the importance of recognizing potential risk factors for sexual reoffense, noting that adopting holistic prescriptions does not necessarily equate to naivety. The Holistic Model instead "moves

[17] According to Andrews et al. (1990), the Risk, Need, Responsivity (RNR) principles state that effective treatment requires the following: (1) risk – delivery of service to high risk cases; (2) needs – target criminogenic needs (e.g., antisocial attitudes, antisocial peers, antisocial personality, poor familial relationships, low education or vocational achievement); (3) responsivity – use styles and modes of treatment (cognitive behavioral) that are matched with client needs and learning styles.

[18] Letourneau et al., specifically studied MST with juveniles with sexual behavior problems.

[19] It is important to note that GLM is not a therapeutic form designed to replace traditional forms of therapy, but instead can be used in combination with the risk management components.

us beyond a narrow, individual pathology model to a comprehensive and systematic approach that understands human behavior as a complex and multi-determined ... system" (Leversee & Powell, 2012:19-8). Table 4 summarizes the Holistic Model components.

Table 4. Holistic Model Therapeutic Components

Risk Reduction / Management	Health Promotion
• Identification of internal risk factors (beliefs, thoughts, fantasies, feelings, behaviors) • Identification of external risk factors (situations, triggers, factors in the environment) • Management of internal and external risk factors through the use of cognitive restructuring, behavior management skills, and adaptive coping responses • Provision of external supervision commensurate with youth's risk and ability to demonstrate internal self-management	• Being Mindful of Normal Adolescent Development • Identifying Strengths and Resources at Multiple Levels: An Ecological Model • Promoting Individual, Family, and Communit "Protective Factors" commonly associated wi "Resiliency" • Meeting Basic Human Needs • Establishing Positive Therapeutic Relationships • Maintaining a Strengths-Based Emphasis • Utilizing Relapse Prevention with a Strengths-Based Emphasis • Promoting the Development of Prosocial Life Goals and Vision for the Future • Enhancing Skill Development • Treating the Impact of Trauma • Treating Co-Occurring Disorders/ Problems • Promoting Healthy Sexuality • Providing Services in a Multi-Sensory Manner • Ensuring the Assessment Process is Ongoing, Individualized, and Comprehensive

Source: Leversee & Powell, 2012. See page 5 for more details.
Note: Health promotion planning is initiated from the beginning as part of a holistic, integrated treatment model along with appropriate risk reduction/management interventions.

It is important to note that the new models like GLM and the Holistic Model are still in the theoretical stage and have yet to be empirically validated to the extent that cognitive behavioral therapy has.

The role of assessment.[20] To be effective, treatment in general is reliant upon the degree to which problematic sexual behaviors can be identified, measured, and assessed accurately. Given the heterogeneity of the juvenile population, determining what static and dynamic risk factors to target in treatment is critical for several reasons (Fanniff & Becker, 2006). Apart from the therapeutic information it provides to the Multi-Disciplinary Team (MDT) to make decisions, differentiating juveniles by their relative risk level provides that juveniles who fall in a lower-risk category receive less restrictive supervision and less intensive treatment. This allows for programmatic resources to be

[20] The SOMB has adopted other risk assessment instruments that measure sexual arousal to a wide range of stimuli. For a list of these and their references to the literature, please see the Juvenile Standards and Guidelines.

efficiently directed towards juveniles who are at higher risk for reoffense (Leversee & Powell, 2012). Several risk assessments have been developed for use by treatment providers. These are listed in Table 5.

Table 5. Juvenile Risk Assessment Instruments

Risk Assessment Name	References
Juvenile Sex Offender Assessment Protocol II (J-SOAP II)	(Prentky & Righthand, 2003)
Estimate of Risk of Adolescent Sex Offender Recidivism (ERASOR)	(Worling & Curwen, 2001)
Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II)	(Epperson, Ralston, Fowers, DeWitt, & Gore, 2005)
Multidimensional Inventory of Development, Sex, and Aggression (MIDSA)	(Knight, 2004)
Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Adolescents and Children (MEGA)	(Miccio-Fonseca LC, Rasmussen LA, 2006)
Juvenile Risk Assessment Tool	(Rich, 2003 & 2007)
Risk Assessment Matrix (RAM)	(Christodoulides, Richardson, Graham, Kennedy, & Kelly, 2005)

Notes: Other generalized risk assessments exist such as the Juvenile Risk Assessment Scale (JRAS), the Structured Assessment of Violent Risk in Youth (SAVRY), and Hare Psychopathy Checklist:Youth Version (PCL:YV).

To date, all of these risk assessment instruments have not been empirically validated, but rather have varying and somewhat inconsistent levels of empirical support. Martinez, Flores, and Rosenfeld (2007) studied the J-SOAP-II, finding it to be accurate in predicting general and sexual reoffense along with the treatment compliance; these were significantly correlated with the total score, but not the individual subscales of the J-SOAP-II. Worling, Litteljohn, & Bookalam, (2010) found that the ERASOR accurately predicted sexual reoffending in the short term of 2.5 years using the "present" clinical judgment ratings, the total score, and the sum of risk factors. However, Hempel, Buck, Cima, and Marle (2011) found limited to no predictive validity in a study of the J-SOAP-II, the J-SORRAT-II, and the ERASOR. Even with some promising results, the accuracy of these risk assessments should be viewed with caution. Despite this limitation, the development of these instruments is a positive step.

Polygraph. The polygraph is widely used as an assessment and adjunct treatment tool nationally. A 2009 national survey of 373 community-based and residential adolescent treatment programs found that half used the polygraph (McGrath et al., 2010). The Center for Sex Offender Management (CSOM) serves as a national center for information and technical assistance to state and local jurisdictions in the effective management of sex offenders. The center was originally formed by the Office of Justice Programs, the National Institute of Corrections (NIC), and the State Justice Institute (SJI) in order to synthesize and disseminate research and effective practices to the field. According to the CSOM (2008), the polygraph has emerged as a tool that may substantially improve the management of individuals who have committed sex offenses. The polygraph is typically used in combination with treatment to accomplish the following:

(1) assess the individual on offending history (frequency, duration, victim type),
(2) monitor treatment and supervision compliance, that is obtain information about whether the youth is currently engaging in high risk behaviors or reoffending,
(3) obtain details about the crime of conviction (relieving the victim of providing this information) and
(4) serve as a mechanism for deterring a juvenile from reoffending.
(5) allow for interventions and treatment to be offered to previously undisclosed victims

In a recent study published by the Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice, Van Arsdale et al. (2012) studied the use of the polygraph with 60 sexually abusive youth. Their results showed that the number of victims disclosed significantly increased with the polygraph, in addition to the types of victims disclosed, information that is critical to the assessment process. The authors concluded:"...the fact that a substantial proportion (40%) of new disclosures revealed child victims aged 6 or younger, many of whom were family members, suggests that polygraph testing may directly impact community safety" (page 74). In a 2003 study of 109 juveniles under supervision in Colorado (Colorado Division of Criminal Justice, 2003), consistent with Van Arsdale et al. (2012), youth disclosed more victims and more types of victims (family, friend, stranger), and many supervision/treatment violations. Perhaps the most important finding was the disclosure of eight previously unknown sibling victims. The siblings had not reported the victimizations, even though the youth was in treatment for sexual abuse. The disclosure of these victims allowed them to get needed services. Additionally, Emerick and Dutton (1993) studied the use of the polygraph on 76 adolescent and found the median age of onset for contact offenses to be age 13, with an average of 3.5 years from first contact offense to detection. Their results also provide evidence that juveniles are found to have of abused a variety of different victims (also known as cross-over) when compared to file information and self-report data.

The research on the polygraph related to juveniles is limited however. The use of the polygraph is a contentious issue in the field with debates about its ethical, policy, and practice implications (Chaffin, 2011). Opponents believe the instrument is intrusive, potentially inaccurate, and its use may undermine the therapeutic relationship, potentially eroding the juvenile's progress in treatment (Vess, 2011). Yet, despite these criticisms there is no significant body of research to support these assertions either.

In light of the limited research available, it may be instructive to examine the current polygraph literature that focuses on adult sex offenders in order to provide a larger context for its use. Proponents of the polygraph argue that its use is analogous to urinalysis testing with substance abuse treatment clients, and its use frees the client of secret keeping, promoting an honest therapeutic alliance. Anecdotal information suggests it helps clients move through the "denial phase" of treatment, a valuable outcome since offenders who are in denial about their offenses do not typically engage in and comply with treatment (Hunter & Figueredo, 2000; Maletzky, 1996). In practice, the polygraph is an aid in obtaining a complete picture of the risk—or lack of risk (Gannon, Beech, & Ward, 2007). In fact, Gannon, Beech and Ward (2007:29) conclude

that there is "reasonable evidence supporting polygraph use in some areas of risk assessment."

The early onset of the sexually assaultive behavior combined with the (relatively long) duration from onset to detection reflects the fact that these crimes occur in secret and few victims report the crime. According to the National Crime Victimization Survey (Truman and Planty, 2012), 27% of sexual assaults of individuals over the age of 12 were reported to law enforcement. Moreover, child victims—the typical victim of juveniles with sexual behavior problems—are the least likely to report the crime. Saunders et al. (1999) analyzed data from a national survey of women and found that only 12% of child sexual assaults were reported to authorities (law enforcement or social services). Smith et al. (2000), studying disclosure of childhood sexual assault, found 28% never reported the abuse until the research interview, and 47% did not tell for 5 years. Finkelhor et al. (1990), analyzing data from a national survey of adult men and women sexually assaulted as children found 33% of women and 42% of men never reported the abuse until the research interview. These low victim reporting rates mean that official records considerably underestimate the actual occurrence of sex offenses.

The use of the polygraph with both adults and juveniles convicted or adjudicated of sex crimes can be traced in part to an influential study by Abel and colleagues (Abel & Rouleau, 1990; Abel et al., 1987; Abel et al., 1988) that found that more than half (53.6%) of 561 adult men who sought voluntary assessment/treatment reported (under a federal certificate of confidentiality) engaging in sexually abusive behaviors before the age of 18. The group that reported onset of sex offending behaviors prior to age 18 each reported committing an average of 380 sex offenses (contact and non-contact) by the time he reached adulthood. Of the 561 men in the study, only 49% had targeted victims in only one age group,[21] 43% reported assaulting both genders, two thirds (65.8%) of those reporting incest assaults also reported victimizing nonrelatives, and 64% of those who said they committed noncontact offenses also committed contact offenses. Most reported multiple paraphilias. It should be noted that only 3% of these offenders had been arrested for a contact sex crime.

Additional self-report studies revealed similar patterns. Weinrott and Saylor (1991) studied 99 male sexual abusers and found 47% reported only one paraphilia, and half of the incest offenders reported victimizing nonrelatives. Wilcox's et al. (2005) small study of 14 adult men in treatment and on probation in the United Kingdom found a mean age of onset of 13.4 years, and the average age from onset to detection of 14 years.

In terms of polygraph studies, English et al. (2000) studied 180 adults in Wisconsin, Oregon and Texas found an average age of onset of 11.2 years for incest offenders and 13 years for non-incest offenders; the researchers estimated 10 years, on average, between onset and detection. Freeman-Longo and Blanchard's (1998) study of 53 adult men found an average age of onset of 18 for rapists and 15 for child molesters; the average time from onset to detection was six years for rapists and 13 years for child molesters. The Simons et al. (2004) study of Colorado prisoners in sex offender treatment found the average time between onset to detection to be 16 years, and only 5.6% of contact offenses were reported in official records. Further, frequently

[21] Researchers used three age groups of victims: children under the age of 14, adolescents (14-17 years of age) and adults (over 17 years).

those who commit sexual offense are reluctant to disclose the full extent of their offending behavior and victimization patterns.

In conclusion, the information obtained from the polygraph also serves as the means by which important services can be delivered to previously undisclosed victims. Because having accurate information is also critical to the development of a meaningful treatment and supervision plan, the use of polygraph testing as part of the treatment process has become a common practice. Ultimately, accurate information from the polygraph is argued to enhance community safety through this information being integrated in the treatment process by preventing future victims. It is based upon these collective findings that the polygraph has been shown to be useful as an adjunct treatment and supervision tool (English et al., 2000). For more information on the polygraph, please see the 2011 Adult Standards and Guidelines Outcome Evaluation in Attachment A.

Summary and Conclusion. There are ongoing studies in a number of areas related to juveniles who commit sexual offenses. This field is still new and the research is still evolving as we learn more about the development of adolescences. The SOMB is contributing to the literature by conducting its own research as demonstrated by the results presented in the legislative report.

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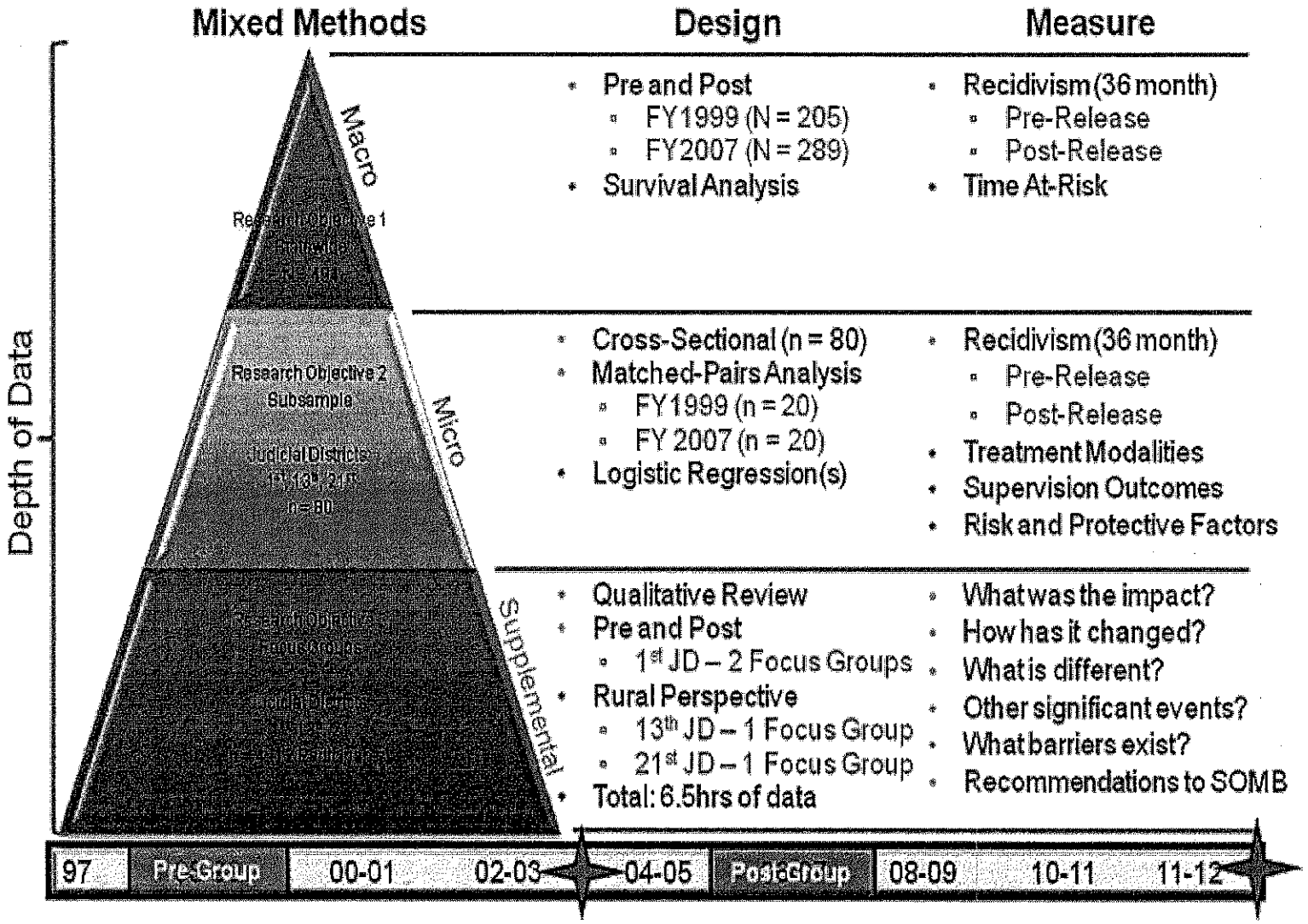
Worling, J. R., & Langstrom, N. (2006). Risk of Sexual Recidivism in Adolescents Who Offend Sexually: Correlates and Assessment. In H. E. Barbaree & W. L. Marshall (Eds.),*The Juvenile Sex Offender (2nd ed.)* (pp. 219-247). New York: Guilford Press.

Worling, J. R., Bookalam, D., & Litteljohn, A. (2012). Prospective Validity of the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR). *Sexual Abuse: A Journal of Research and Treatment*. 24(3) 203-223.

Ybarra, M. L., & Mitchell, K. J. (2005). Exposure to internet pornography among children and adolescents: A national survey. . *CyberPsychology & Behavior, 8(5)*, 473-486.

APPENDIX B – RESEARCH DESIGN



APPENDIX C - LITERATURE REVIEW INCLUSION CRITERIA

Check the Box If "Yes"

- ☐ 1. Does the article pertain to Juveniles who have committed sexual offenses?
- ☐ 2. Is the article related to the assessment, evaluation, treatment, and behavioral monitoring of juveniles who have committed sexual offenses?
- ☐ 3. Does the article include data or statistics pertaining to outcomes? (e.g. predictors of risk, treatment outcomes, program outcomes, recidivism rates)
- ☐ 4. Are different groups analyzed and compared to each other?
- ☐ 5. Are the variables in the article measured using clear definitions? Example: Recidivism is measured using reconvictions; risk was measured using the J-SOAP II; anti-social behavior is measured by (1) instigation and involvement in fights and (2) vandalism and the destruction of property.
- ☐ 6. If there is no data or statistics, does the author make his arguments using sound logic and unbiased language?
- ☐ 7. Does the author make conclusions drawn based on data and analysis?
- ☐ 8. Is the article unbiased?

With the exception of question 4, any NO response excludes that article from the literature review. If all responses are YES (question 4 is negotiable), the article shall be included in the literature review.

APPENDIX D - FILE REVIEW DATA COLLECTION FORM

Juvenile Standards Evaluation-DATA COLLECTION FORM

Sentenced between: 7/1/1998 – 6/30/1999 OR 7/1/2006 - 6/30/2007

Judicial District File Review: 1st 13th 21st

File Review: Probation DYC (Detention Commitment) DHS

DCJ ID Number:_____ ML Number:_____ Trails Number:_____

Is Human Services assigned to this case as well? 0. No 1.YES

Name:_____

AKA:_____

Social Security
Number:_____

FBI Number:_____

SID Number:_____

Date of Birth:_____/_____/_____

Gender: O. Male 1. Female

Ethnicity:
1. Anglo/White
2. African American
3. Hispanic
4. Native American
5. Asian
6. Other

Primary/Most serious Sex Offense Case Number:_____County:_____

Any changes of venues or case numbers? O. No 1. YES
If yes, new case number1:_____County:_____
If yes, new case number2:_____County:_____

Supervised Jurisdiction1:_____County1:_____
Supervised Jurisdiction2:_____County2:_____
Supervised Jurisdiction3:_____County3:_____

Concurrent Number of...
Charges:_____
Sexual Offense Charges:_____
Non-violent, non-sexual charges:_____
Violent, non-sexual charges:_____
Failure to Register charges:_____
Felonies:_____
Misdemeanors:_____

1) Primary/Most Serious Charged/Filed Offense:
_____

2) Primary/Most Serious Pled/Adjudication Offense:
_____

3) Date of Adjudication: ____/_____/_____

4) Date of Sentence:_____/_____/_____

5) Sentence:
1. Probation
2. Probation/Detention
3. DYC (Commitment)
4. Other,_____

6) Was the juvenile under criminal justice supervision at time of this offense? O. NO
1. Yes 9. Do Not Know

7) Has the juvenile had any prior adjudications?
1. No
2. Yes (circle all that apply)
I. Misdemeanor
II. Felony
III. Municipal Level
IV. Petty
V. Non-violent Sexual Offense
VI. Violent Sexual Offense
VII. Non-Violent, non-sexual
VIII. Violent, non-sexual
IX. Do Not Know

8) Has the juvenile had any prior deferred sentences/judgments? O. No 1. Yes 9. Do Not Know

9) At the time of the offense (or arrest), which best described the juvenile's living situation?
1. Living with immediate family
2. Living with legal guardians and/or foster family
3. Living in a residential facility
4. Other,_____
9. Do Not Know

10) At the time of offense, was the juvenile attending school?
1. No
2. Yes
3. What grade?_____
4. What School District (write name of school if don't know what district)
_____
9. Do Not Know

11) At the time of offense, was the juvenile active in any extra-curricular activities?
0. No
1. Yes
9. Do Not Know

12) Did the juvenile fail either 1st or 2nd grade?
0. No
1. Yes
9. Do Not Know

13) Did the juvenile have an Individualized Education Plan at the time of offense/arrest?
0. No
1. Yes
9. Do Not Know

14) Did the juvenile change schools while under supervision?
0. No
1. Yes
Date changed school1:_____/_____/_____
Reason for changing shool1:_____
_____

Date changed school2: _____/_____/_____
Reason for changing school2:_____
_____
Date changed school3: _____/_____/_____
Reason for changing school3:_____
_____

9. Do Not Know

15) Did the juvenile get expelled from school or drop-out of school while under supervision?

0. No
1. Yes
   Explain why:_____
   _____
9. Do Not Know

16) Did the juvenile graduate high school or obtain a GED while under supervision?

0. No
1. Yes
   a) DHS Diploma
   b) GED
   c) Do Not Know
9. Do Not Know

17) At the time of offense, was the juvenile employed:

0. No
1. Yes
   I. Full-time
   II. Part-time
   III. Summer job
   IV. Do Not Know
9. Do Not Know

18) When NOT a student, was the juvenile employed while under supervision?

0. No
1. Off and On
2. Summer job
3. Yes, all of the time:
   I. Full-time
   II. Part-time
   III. Do Not Know
9. Do Not Know
10. N/A-Juvenile was always attending school
11. N/A-Juvenile was too young to be employed

19) At the time of offense (or within 6 months prior to the offense), did the juvenile have a mental health diagnosis?

0. No
1. Yes:_____
9. Do Not Know

20) At the time of offense (or within 6 months prior to the offense), did the juvenile have any other medical diagnosis?

0. No
1. Yes:_____
9. Do Not Know

21) At the time of offense (or within 6 months prior to the offense), was the juvenile prescribed any psychotropic medications?

0. No
1. Yes:_____
9. Do Not Know

22) Date of Pre-Trial Evaluation or first Offense-Specific Evaluation: ___/___/_____

23) Date of Pre-Sentence and Post-Adjudication Evaluation: ___/___/_____

24) Risk Level per offense-specific evaluation (evaluation most recent prior to sentence):
1. Low
2. Low-Moderate
3. Moderate
4. Moderate-High
5. High
6. Other, _____
9. Do Not Know

25) Placement recommendation per evaluation:
1. Out-patient
2. DHS out-of-home placement /foster care
3. DYC correctional placement
4. Other, _____
9. Do Not Know

26) Actual placement:
1. Out-patient
2. DHS out-of-home placement /foster care
3. DYC correctional placement
4. Other, _____
9. Do Not Know

27) Reason for placement (if different than recommendation):
_____
_____
_____
_____
_____
_____
_____

28) Who was involved in the MDT? Circle all that apply:
1. Treatment Provider
2. Supervising Officer/Agent
3. Polygraph Examiner
4. Victim Representative
5. DHS Caseworker
6. Caregiver in any out-of-home placement
7. Family member
8. GAL
9. School Representative
10. Other, _____

29) Was there documentation of the MDT meeting regularly (a minimum of quarterly)?
0. No
1. Yes

30) Has the supervising officer noted any concerns with supervision that resulted in a recommendation for change in supervision level or placement level? 0. No 1. Yes

Please
Explain:_____

31) Status at termination of supervision?
0. Positive completion of supervision
1. Neutral completion of supervision
2. Negative discharge/termination of supervision
31a) If supervision was revoked, reason for revocation:_____

32) What was the criminal justice supervision end-date? _____/_____/_____

Treatment Information

33) Modalities Used (Circle All that Apply):
1. Group Therapy
2. Individual Therapy
3. Family Therapy
4. Multi-Family Groups
5. Other, _____

34) Did the juvenile's family participate in family therapy?
0. No
1. Yes, consistently, during the entire case
2. Yes, off and on
9. Do Not Know

35) Did the juvenile's family complete Informed Supervision therapy or training?
0. No
1. Yes
9. Do Not Know

36) Did the juvenile participate in victim clarification procedures?
0. No
If NO, please explain: _____
1. Yes
9. Do Not Know

37) Did the juvenile participate in family reunification procedures?
0. No
If NO, please explain: _____
1. Yes
9. Do Not Know

38) Were there any changes in treatment agencies?
0. No
1. Yes
38a) Were the recommendations followed though...
1. All of the time
2. Some of the time
3. Never
If answered some of the time or never, explain why:
_____
_____
_____

40) Has the treatment provider noted any concerns in treatment that would affect their placement or supervision level?
0. No 1. Yes
Please Explain:
_____

41) Did the juvenile get moved to a different placement or living situation/arrangement?
0. No
1. Yes
Type 1: _____
Date of Placement1: _____/_____/_____
Reason for Placement1: _____
Date placement1 ended: _____/_____/_____
Reason placement 1 ended: _____
Type 2: _____
Date of Placement2: _____/_____/_____

Reason for Placement2:____
Date placement2 ended: _____/_____/______
Reason placement 2 ended: ____________________________________
Type 3: ____
Date of Placement3: ____/_____/______
Reason for Placement3:____
Date placement3 ended: _____/_____/______
Reason placement 3 ended: ____________________________________

42) Status at Treatment Completion:
0. Positive Completion of Treatment
1. Neutral Completion of Treatment
2. Negative Discharge/Termination of Treatment

43) What was the treatment discharge date? ____/____/______

Polygraphs:

DATE	TYPE	OUTCOME	DISCLOSURES MADE
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation
	1. Sex History 2. Maint/Monitoring 3. Specific Issue	1. Significant Reaction 2. Insignificant Reaction 3. Inconclusive 4. Purposeful Non-cooperation	0. No 1. Yes 1. Criminal Violation 2. Technical Violation

Were polygraphs contra-indicated? 0. No 1. Yes

Physiological Assessments:

DATE	TYPE	Devious Arousal/Interest Indicated?	COMMENTS
	1. Abel 2. PPG	0. No 1. Yes	
	1. Abel 2. PPG	0. No 1. Yes	
	1. Abel 2. PPG	0. No 1. Yes	

Were physiological assessments contra-indicated? 0. No 1. Yes

Criminal and Technical Violations Which Resulted in a Sanction:

Date of Violation (when appropriate)	Date found out about violation (when applicable)	How violation was found	Description of Violation	Result/Sanction

OTHER COMMENTS REGARDING THIS CASE:

APPENDIX E - FOCUS GROUP INTERVIEW GUIDE

Number	Question	Follow-up Topics
1	Based on your experience, how has the implementation of the Juvenile Standards and Guidelines changed the nature in which you treat and manage juveniles who have committed sexual offenses? How has it either worsened or improved your perception of Colorado's system of interventions and containment?	
2	What are some of the major differences you perceive in the field today as compared to the 1990's era prior to the Juvenile Standards and Guidelines?	Legislation, polygraph utility, technology, intervention techniques, level of information, victim services, informed supervision
3	What are some considerations to treatment and supervision that have changed overtime as a result of the Standards and Guidelines? Were there any significant events that impacted your processes and procedures?	Do what you can, School Notification, Medicaid Laws, Registration Laws, Diversion vs. Adjudication, Restraint, Risk Assessments
4	How do you feel about the SOMB's policy efforts in adopting evidence-based practices?	Major Initiatives
5	What are some current barriers to the ongoing practice of the Juvenile Standards and Guidelines?	School Integration, MDT Collaboration, Reintegration, Community Notification Responses, DD
6	In your experience, how has the Juvenile Standards and Guidelines contributed to outcomes for juveniles who have committed sexual offenses? Is it better now, than it was prior to FY1997?	Treatment, Supervision
7	In thinking about all aspects of the Juvenile Standards and Guidelines, what advice would you give to the SOMB to meet the needs of Treatment Providers in treating juveniles who have committed sexual offenses?	
8	What do you think of these statistics: (Some statistics will be presented from the file review data)	
9	Does this change your previous answers at all? If so, please explain how and why?	